CHANGES TO THE TARIFF FOR POST-DISCHARGE SUPPORT AND ADDITIONAL FUNDING FOR RE-ABLEMENT IN 2010-11 AND FUTURE YEARS

The *Revision to the Operating Framework for the NHS in England 2010-11* described some changes to payments for readmissions which took effect from 1 December 2010. These changes are linked to the additional funding of £70m that went to the NHS for re-ablement in 2010/11 and over the remainder of the SR. The purpose of this funding is to reduce avoidable re-admissions, bolster community capacity and preventative services; to reduce delayed discharge where we expect growth in overall capacity to assist

Operating Framework for the NHS in England 2010 -11

The *Payment by Results guidance for 2010-11* includes, as it has done for a number of years, a flexibility for commissioners not to pay providers for avoidable emergency readmissions. The flexibility is described in paragraphs 402 to 405 of the guidance, but the notable points are that the commissioner may withhold payment if the readmission is within 14 days of discharge and above a locally agreed rate of readmissions.

Further detail on the position for 2010-11 is contained in **Appendix 1**.

Autumn guidance and the additional £70m

The Health Secretary announced on October 5th that £70 million of extra funding would be allocated to Primary Care Trusts (PCTs) to be spent this financial year across the health and social care system to enable the NHS to support people back into their homes after a spell in hospital through re-ablement. and therefore contribute to changes to the post-discharge tariff announced in June. Allocations to PCTs, **based on the NHS formula**, were made on 4 November.

PCTs and councils will have already drawn up local plans and share these with SHAs. PCTs and councils should ensure the money is spent on re-ablement, making use of both in-house services and additional capacity in the independent sector.

The beneficiaries will be people leaving hospital, predominantly older people but also people who need to get back on their feet and get back to work.

Local plans for re-ablement in 2010/11

SHAs should be ensuring that each PCT had a local plan, developed with their Local Authority and local FT/NHS Trusts including monitoring arrangements, in place by the end of December 2010.

The plan should include a brief analysis of local health and social care services available to support people who are discharged from hospital. It should also include some analysis of the gaps that may exist and where the PCTs jointly (with council and providers) plan to spend the share of the £70m during this financial year according to local priorities. Spending in this financial year would therefore be a main feature of

any local plan which might point to further areas for spending in the medium and longer term.

This should not be a substitution of the existing council services by the NHS but may involve support from the NHS for existing council services facilitating discharge from hospital. The main drivers for the policy are threefold:

- avoiding people being readmitted to hospital at the same time as stabilising their condition to what it was before they entered hospital;
- promoting integrated and joint working in health and social care; **and**
- facilitating discharge from hospital in order to avoid delays.

A council simply pulling out of its existing services is not an example of the latter and is clearly not the intention of the policy. The additional funding is an opportunity, given the changed responsibilities, for the NHS and social care to work together to consider what would best serve local people in this regard over the short, medium and longer term.

<u>Relevant Extracts from the Operating Framework for the NHS in England 2011-12</u>

"On 20 October 2010, the Government announced the details of the Spending Review covering the four years from 2011/12 to 2014/15. This reflected the Government's commitment to protect health with the total health budget increasing by £10.6 billion over four years. Within this, total revenue increases by £11.1 billion with capital falling by £0.5 billion over the same period. That settlement needs to be considered in the context of reducing management costs and Quality, Innovation, Productivity and Prevention (QIPP) productivity gains which will release up to £20 billion more funding into frontline services for patients over the four years. In 2011/12, the settlement includes an explicit provision from health resources of £800 million, which NHS commissioners will have available to spend on measures which support social care and benefit health in agreement with social care commissioners." (page5)

"To support that transition, there will be a single planning and accountability process for 2011/12 that captures the basis on which NHS organisations will be held to account in terms of quality, resources and reform. It is important that the planning and accountability process supports joined up delivery. For example, NHS commissioners need to demonstrate how they can support the challenges in social care. Reduced length of stay in hospital beds can put greater pressure on social care places. That is why we have put the responsibility on PCTs to secure post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge." (page 6)

PCTs will receive specific allocations to support social care. PCTs will transfer this funding to local authorities for spending on social care services to benefit health and to improve overall health and social care outcomes. PCTs and local authorities will need to agree appropriate areas for social care investment and expected outcomes, and will work together in order to achieve these. The Government has recently set out its *Vision for adult social care: Capable communities and active citizens*[6] and updated its carers' strategy, *Recognised, valued and supported: next steps for the Carers*

Strategy[7] which should be taken into account when agreeing local investment plans. (page 16)

"For example, QIPP aims to release hospital capacity to allow the better use of community services. The requirement to reduce length of stay needs to be considered in the context of higher day case rates, increased responsibility on acute providers around emergency readmission rates and sufficient care home places. Thus, a PCT could meet its responsibilities to provide post-discharge support by securing additional social care places ensuring that, where clinically appropriate, patients are discharged both quickly and with sufficient capacity to support them outside hospital." (page 31)

"In 2011/12 PCTs will receive allocations totalling £648 million to support social care. Indicative allocations, totalling £622 million, will also be set out for 2012/13[29]. This is in addition to the funding for reablement services that is incorporated within recurrent PCT allocations of £150 million in 2011/12 rising to £300 million from 2012/13."

"These allocations are based on the adult social care relative needs formulae, in order to reflect social care need." (page 50)

"PCTs will need to transfer this funding to local authorities to invest in social care services to benefit health, and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the 2006 NHS Act.

PCTs will need to work together with local authorities to agree jointly on appropriate areas for social care investment, and the outcomes expected from this investment. This could include current services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services. The Department would expect these decisions to take into account the Joint Strategic Needs Assessment for their local population, and the existing commissioning plans for both health and social care. PCTs should work with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms." (page 51)

<u>Payment by Results and the post-discharge tariff in 2011/12</u>

In 2011/12 savings will also accrue at commissioner level from the new policy on non-payment for emergency readmissions to hospital within 30 days of discharge. These savings will be subject to slightly different arrangements (see below) as the intention from 2012/13 is to change the national tariff so that the money is retained by the hospital which will then have the responsibility for care needed in the 30 days following discharge from hospital.

From 1 April 2011, the *Revision to the Operating Framework* anticipates the principle that hospitals will not receive further payment for patients readmitted within 30 days of discharge. This is linked to the policy that provider organisations will become responsible for some aspects of care for patients in the 30 days after their discharge.

SUS PbR will be amended to ensure that readmissions within the 30 day time period are flagged. The draft *Payment by Results guidance for 2011-12* was issued for "road test" in December and includes more detail on the operation of this rule and the savings which are made by commissioners. Further details are at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122717

It will be clear from the above that the intention is towards a progressive strengthening of the rules around readmissions, from optional to mandatory non-payment, from 14 days to 30 days, and from thresholds to individual patients.

Early implementer sites

The revision to the Operating Framework in June requested expressions of interest to be an early implementer site to help with the tariff. Details of those sites taking part in phases 1 and 2 of this are at **Appendix 2**. The sites will be gathering important information and data to inform the changes to the tariff that will take effect for readmissions funding from April 2011 and 30 day discharge responsibilities from April 2012. They will be working on different models, governance and some elements of good practice. The work should be completed by the summer.

Further Technical Information on Aspects of Re-ablement

Appendices 3, 4 and 5 contains some useful information on aspects of re-ablement based on queries from PCTs and councils since the announcement of additional funding for re-ablement.

Appendix 1

Revision to the Operating Framework for the NHS in England 2010-11

The *Revision to the Operating Framework for the NHS in England 2010-11* states that from 1 December 2010, providers and commissioners should apply the provisions of the *Payment by Results guidance for 2010-11* if they are not already doing so. In other words, between 1 December 2010 and 31 March 2011, non-payment for avoidable emergency readmissions within 14 days of discharge and above a locally agreed rate will be a requirement. SUS PbR flags readmissions within 14 days. Some health economies have been planning to move to a position where readmissions within 30 days of discharge would not attract payment from 1 December 2010 - locally agreed approaches between providers and commissioners are not precluded.

The locally agreed rate should be for the final four months of 2010-11 and should not be retrospectively applied for the whole year. Given that the requirement to apply the provisions of the *Payment by Results guidance for 2010-11* will only operate for four months, issues such as defining avoidable readmissions and calculating historic rates will be for local agreement. No further guidance will be issued for 2010-11.

From 1 April 2011, the *Revision to the Operating Framework* anticipated the principle that hospitals will not receive further payment for patients readmitted within 30 days of discharge. This is linked to the policy that provider organisations will become responsible for some aspects of care for patients in the 30 days after their discharge. SUS PbR will be amended to ensure that readmissions within the 30 day time period are flagged. The draft *Payment by Results guidance for 2011-12* was issued for “road test” in December and includes more detail on the operation of this rule and the savings which are made by commissioners. Further details are at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122717.

It will be clear from the above that the intention is towards a progressive strengthening of the rules around readmissions, from optional to mandatory non-payment, from 14 days to 30 days, and from thresholds to individual patients.

Appendix 2

Phase 1 and 2 Early Implementer Sites

Phase 1 Sites

Organisation
Alder Hey
NHS Camden and LB Camden
Community Care Western Cheshire
NHS Cumbria
NHS Dorset
Hampshire Community
Hertfordshire CC and Hertfordshire PCT
Milton Keynes Community
Northumbria H/care FT
Salford Community Health
South West SHA
Southport and Ormskirk Trust

Phase 2 Sites

NHS Blackpool Comm
Greenwich Comm (pct)
RNOH
Surrey Comm Health
Sussex Comm NHS T
NHS Telford and Wrekin
University Hosp North Staffs (UHNS)

Appendix 3

A Definition of Re-ablement

Below is a definition of re-ablement that has been developed through councils' work on homecare re-ablement and which is essentially a form of intermediate care:

> *"Re-ablement is an active period typically of up to 6 weeks of intense activity and support designed to promote people's independence. This is a preventive measure that can reduce people's need for both acute hospital care and can help people to continue living at home for longer."*

However, in the context of the additional funding in the Spending Review going to the NHS for re-ablement, this has a much wider meaning. It could include recovery following the acute hospital episode, rehabilitation and homecare re-ablement in the sense of getting the person back to the position, or improving upon, the position that they were in before the acute hospital phase (whether that be returning to employment, returning home, etc). It could involve physiotherapy, an intervention by a dietician - whatever the person needs following acute care.

Clearly, not everyone will need such an extended length of care, and not everyone will need any social care input. This policy is not meant to pay for all social care costs in that period. There may be some replacement of some of the costs of a council's re-ablement services and there may be additional interventions or higher levels of care that are necessary temporarily to get the person back to work or living independently.

Appendix 4

The Legal Basis for Re-ablement

LAC (2010)6, issued in October 2010, does not alter the guidance given in the Building Telecare In England guidance. Indeed, the Telecare Guidance closely follows the wording of the Community Care (Delayed Discharges etc) Act (Qualifying Services) (England) Regulations 2003 (2003/1196).

LAC (2010)6 reminds local authorities that they may need to provide equipment free of charge as part of a re-ablement package (or as a stand alone service) where the conditions under the 2003 Regulations are met - which means that the equipment must be provided for the purposes of nursing at home or aiding daily living.

It is possible for re-ablement to be provided under section 15 of the Community Care (Delayed Discharges etc.) Act 2003 and (Qualifying Services) (England) Regulations 2003 (2003/1196). It is also possible for re-ablement to be provided under section 29 National Assistance Act 1948. The definition of qualifying service in section 15(3) in the 2003 Act refers to section 17(2)(a) of the Health and Social Services and Social Security Act 1983 which in turn refers to section 29 NAA. The definition of qualifying service in section 15(3) of the 2003 Act also refers to other legislation.

Where section 15 and regulations under it provide for qualifying services to be provided for free then they must be provided for free and no charges can be made under section 17 of the 1983 Act for services provided under section 29 of the NAA. That is, the service must be provided free in the circumstances and subject to the conditions that are set out in the 2003 Act and Regulations.

The NHS will provide reablement services under section 2 or 3 of the NHS Act. Services provided under section 2 or 3 of the NHS Act are not qualifying services and as such do not fall within section 15 of the 2003 Act or regulations made under section 15. To be intermediate care, it must be provided under section 29 of the NAA, section 45(1) of the Health Services and Public Health Act 1983, Schedule 20 to the NHS Act 2006 or section 2 of the Carers and Disabled Children Act 2000. So, the person will get 30 days of free NHS care followed by up to six weeks of free intermediate care. Regulation 4(2) of the 2003 Regulations says –

> *"(2) A period of intermediate care which begins on or after these regulations come into force is required to be provided free of charge to any person to whom it is provided for any period up to and including six weeks."*

So, the period begins with the provision of intermediate care, "intermediate care" being a qualifying service. The period does not begin with the date of discharge from hospital, for example.

Appendix 5

The Interface with NHS Continuing Healthcare (NHS CHC)

Where a person is eligible for NHS CHC, the NHS has responsibility for both the person's health needs and their social care needs.

Assessment of eligibility for NHS CHC should take place before eligibility for LA social care services is considered but should be after appropriate post-discharge NHS-funded support has been provided to maximise the individual's potential.

The National Framework for NHS CHC therefore encourages PCTs to avoid assessing for NHS CHC within the hospital setting as this may not reflect an individual's capacity to maximise their potential after further support. The Framework asks PCTs to consider whether further NHS-funded services to maximise the individual's potential should be provided and to defer assessing for NHS CHC until the person's long term future needs are clearer.

Examples given of such interim services are therapy and/or rehabilitation, intermediate care or an interim package of support in an individual's own home or in a care home (such services are funded by PCTs under their overall powers under section 3 of the NHS Act 2006). There is clearly a similarity in the aims of the above to those of wider re-ablement services.

In discussions regarding the 30 day policy it has been proposed that in the future the expectation will be that assessment for NHS CHC eligibility should, at the earliest, usually take place within the 30 day period as part of assessment and care planning for future care and support needs beyond that time.

However there is the need to clarify where responsibilities will lie *after* the 30 days if the person is considered to be in need of further re-ablement before assessing for CHC and how this will fit with wider re-ablement policy. It is proposed that the route through this is to set out that:

> a) when PCTs come to assess an individual for NHS CHC towards the end of the 30 day period, they should consider whether the individual would benefit from further re-ablement before carrying out a CHC assessment.
>
> b) if re-ablement services are considered appropriate, these should be funded by the PCT under their section 3 NHS Act 2006 powers. The PCT may consider that the individual also needs additional support over and above those provided through re-ablement services during this period and these should be provided as appropriate. The key issue is that, where assessment for CHC has been deferred, it is the PCT rather than social care that is responsible for funding such services whether or not they are re-ablement services.

Under the National Framework for NHS Continuing Healthcare (NHS CHC), when a person is being discharged from hospital, PCTs should consider whether further NHS-funded services are required to maximise the individual's potential and enable an accurate assessment of future needs before making a decision on NHS CHC eligibility. In the future, the services provided during the 30 days after discharge

should usually meet such needs for this period. However a PCT should consider whether a person has a need for further re-ablement or other services beyond the 30 day period before determining eligibility for NHS CHC. In such circumstances any re-ablement or other services to meet needs in the interim should be funded by the PCT until eligibility for NHS CHC has been properly assessed.